

# **Individual Support Plan (ISP) Instruction Manual**

**March 2009**

# Table of Contents: Individual Support Plan Instructional Manual

<b>COMPLETING AN INITIAL OR ANNUAL INDIVIDUAL SUPPORT PLAN .....</b>	<b>3</b>
Purpose of the Individual Support Plan (ISP) Manual.....	3
Required Forms.....	3
Supports and Services Authorization Instructions and Form .....	5
Signature Page Instructions and Form.....	11
Personal Summary Instructions and Form .....	14
Supports and Services Instructions and Form .....	19
Supports and Services Addendum Instructions and Form .....	24
Other Forms Associated With an ISP .....	28
Plan Development Authorization Cover Sheet .....	28
Health and Well-Being Checklist Instructions and Form.....	29
Extenuating Circumstances Instructions and Form.....	31
Plan Developer ISP Checklist .....	33
Plan Monitor Status Summary Guidelines and Instructions.....	34
Plan Monitor Status Summary .....	37
How to Initiate an Addendum.....	40
<b>OTHER INFORMATION .....</b>	<b>41</b>
Durable Medical Equipment (DME) .....	41
Guidelines for Developing Person Centered Plans that Encourage Independence.....	43
Adding Waiver Services When There is an Existing ISP .....	43
Change in Plan Developer Within the Plan Year.....	44
Statewide Bureau of Developmental Disabilities Phone List .....	44
Web Site Links.....	45

# Instructions for Completing an Initial or Annual Individual Support Plan

## Purpose of the Individual Support Plan (ISP) Manual

The purpose of the Individual Support Plan (ISP) Instruction Manual is to help plan developers complete all of the forms required for an ISP.

## Required Forms

Plan developers must complete each of the following required forms and submit them to the Idaho Center for Disabilities Evaluation (ICDE) **completed** before an initial or annual ISP can be processed for authorization:

- Supports and Services Authorization form
- Signature Page form
- Personal Summary form - includes Assessed Needs and Transition Plan, if a Transition Plan is applicable
- Supports and Services form(s)
- Health and Well-Being Checklist
- Extenuating Circumstances form  
**Note:** Use this form if the requested services put the participant over the assigned budget amount
- History and Physical that is current within 365 days  
**Note:** all plans will be returned as incomplete if not received by the ICDE
- Safety Plan, if applicable

**Reminder:** Implementation plans for certified family homes and supported living facilities must be submitted no later than 14 days after the initial provision of service and then annually for plan authorization.

For **annual ISPs**, plan developers must **also** submit the following documents:

- Six month Plan Monitor Status Summary
- Six month Provider Status Reviews
- Program Implementation Plans (As part of the Negotiated Service Agreement for a Certified Family Home or for Supported Living **only**)

For **ISP addendums**, **only** the following documents must be submitted:

- ISP Supports and Services Addendum form
- Additional justification for services (if requested)
- Extenuating Circumstances form (if requested services put the participant over the assigned budget amount or keep them above it)

**Important:** Before submitting the forms listed, a plan developer should ensure the following requirements are met:

- All forms must be typed.
- All fields within the forms must be completed.

**Note:** Forms that do not comply will be returned to the plan developer.

Assessments and documents initiated by the ICDE include:

- Physician's letter
- Medical, Social and Developmental Assessment Summary
- SIB-R report

Assessed needs for the ISP can be obtained from:

- History and Physical
- SIB-R (report only)
- Medical, Social, and Developmental Assessment Summary
- Developmental evaluations- including comprehensive and specific skill assessments
- Functional assessments
- Psychological evaluations
- Physical therapy/occupational therapy/speech assessments
- Agency conducted medical/social histories

## Supports and Services Authorization Instructions and Form

**Note:** This form is provided as an example and can not be used as an actual Individual Support Plan (ISP) authorization page.

**Participant Name:** Type the name of the participant exactly as it appears on their Idaho Medicaid card.

**Medicaid ID#:** Type the first seven digits of the participant's Medicaid identification number as listed on their Idaho Medicaid card.

**Initial Plan:** Check this box if this is the first ISP being submitted for the participant.

**Annual:** If this is not an initial plan, check this box.

**DD Waiver Participant:** Check the "Yes" or "No" box according to the participant's waiver status.

**Plan Developer:** Type the first and last name of the plan developer.

**Plan Developer Agency and Address:** Type the agency's name and mailing address where the plan developer is employed. Be sure to include the city, state, and ZIP code.

**DD Waiver Participant/Guardian Initials:** The participant/guardian must indicate by initialing that they have chosen developmental disability (DD) waiver services over intermediate care facility (for Developmentally Disabled)/mentally retarded (ICF/MR) placement.

- If the participant is the guardian and unable or unwilling to sign due to "individual special circumstances" (e.g., refusal to sign at that time, participant is tactile defensive), the plan developer must document the case specific reason(s) why.

**Service Provider Column:** List in this column all DD waiver and state plan service providers who are delivering services to the participant. All routine costs that support a participant in the community must be listed. Provider reimbursement rates can be found at [www.healthandwelfare.idaho.gov](http://www.healthandwelfare.idaho.gov). Select Medical>Medicaid/CHIP>Medical Providers>Medicaid Fee Schedule.

DD Waiver and state plan services are as follows:

- DD Waiver - Residential Habilitation including Supported Living, Certified Family Home, and Agency Affiliation. Other waiver services include: Chore Services, Respite Services, Community Supported Employment (CSE), Non-Medical Transportation, Environmental Accessibility Adaptations, Specialized Medical Equipment, Personal Emergency Response Systems (PERS), Home-Delivered Meals, Nursing Services, Behavior Consultation/Crisis Management and Adult Day Care.
- State Plan - Plan Development, Plan Monitoring, Service Coordination, and Developmental Disabilities Agency (DT, PT, OT, Speech, Supportive Counseling).
- Other Medicaid services - Mental Health Services, Personal Care Services (PCS), Durable Medical Equipment, Interpretive Services, and Medical Transportation.

**Service Type Column:** Identify the service delivered by the provider (e.g., developmental therapy, supportive counseling).

**Proposed Start Date and End Date Column:** Type the proposed start and end date for each service delivered.

**Service Code Column:** List the service code that corresponds with the DD waiver or state plan service. This service code can be found under the “Procedure Code” and “Modifiers” columns of the most current rate chart (see Web site listed above).

**Units & Frequency of Service Column:** This is a two-step process.

Step 1 - Units	Step 2 - Frequency
<p>Based on the service’s unit time value determine the total number of units being requested for a particular service or support.</p> <p>Examples of units and their time value are as follows:</p> <ul style="list-style-type: none"> <li>• 1 unit = 15 minutes</li> <li>• 1 unit = 1 day</li> <li>• 1 unit = 1 mile</li> <li>• 1 unit = 1 visit</li> </ul> <p>For example: Transportation ⇒ If 1 unit = 1 mile, and a transportation provider is requesting 50 miles of service, then 50 miles = 50 units and 50 would be the total number of units to request.</p> <p>List the number of units being requested in the “Units and Frequency of Service” column.</p> <p><b>Reminder:</b> When a service provider is requesting hours of service, the number of hours requested must be multiplied by 4 to determine the total number of units. (Number of hours x 4 = Number of units.)</p> <p>For example: 10 hours x 4 units per hour = 40 units</p>	<p>On the ISP, units must also have a frequency. To determine frequency, identify how often the units of service are being delivered.</p> <p>List the frequency along with the units in the “Units &amp; Frequency of Service” column.</p> <p>Examples of frequency are:</p> <ul style="list-style-type: none"> <li>• 1 unit/day (i.e. Supported Living: Daily rate)</li> <li>• 40 units/day (i.e. Supported Living: Hourly rate)</li> <li>• 80 units/week (i.e. Developmental Therapy)</li> <li>• 1 unit/month (i.e. Service Coordination)</li> <li>• 12 units/year (i.e. Developmental Evaluation)</li> <li>• 50 units/week (mileage)</li> </ul>

**Unit Cost Column:** Refer to the “Amount Allowed” column of the rate chart for the dollar value of each unit. List this dollar value in the “Unit Cost” column. Do not use the hourly dollar value associated with a service code, only use the dollar value associated with a unit.  
Example: For code H2032: 1 unit = \$4.53

**Annual Cost Column:** Determine the annual cost for a “Service Type” using this formula:

Units and Frequency x Appropriate Multiplier x Cost/Unit = Annual Cost

- **Units & Frequency:** As identified in the “Units and Frequency of Service” column for this service. Examples: 1unit/day, 10 units/week, 3 units/month, or 1 unit/year
- **Multiplier:** The multiplier used is based on how often a service is being provided (i.e., daily, weekly, monthly, one time, or annually). Use the frequency formula listed below to determine the correct multiplier to use in your calculation:
  - Daily = 365 days/year
  - Weekly = up to 52 weeks/year
  - Monthly = 12 months/year
  - One time or annually = 1
- **Cost/Unit:** As identified in the “Unit Cost” column for this service.

Examples:

1. 1 unit/day x 365 days/ year x \$53.39/unit = \$19,487.35/year (shown in the table below)
2. 160 units/week x 52 weeks/year x \$3.24/unit = \$26956.80/year
3. 8 units /month x 12 months/ year x \$6.42/ unit= \$616.32/year
4. 48units /year x 1 x \$4.53/unit = \$217.44/year

SERVICE TYPE	PROPOSED START DATE AND END DATE	SERVICE CODE	UNITS & FREQUENCY OF SERVICE (#/DAY/WEEK/MONTH)	UNIT COST (\$/HR/DAY)	ANNUAL COST
DEVELOP- MENTAL THERAPY	1/1/09 - 12/31/09	97537	20 units/week	5.01	<b>5210.40</b>

**Requires IPA # Column:** This column is for Department of Health & Welfare use only. If the box for the “Service Type” contains a number, the service has been prior authorized.

**Assigned Budget Amount:** Type the assigned budget amount from the participant’s Eligibility Notice. Plan developers should do an Extenuating Circumstances form, if necessary.

**Medicaid Annual Total:** Add the totals for both DD waiver and state plan services and write it on this line.

**Participant Signature Line:** The participant must sign (or mark or stamp) on this line if the participant is the guardian. If the participant is unable or unwilling to sign due to “individual special circumstances” (e.g., refusal to sign at that time, participant is tactile defensive), the plan developer must document the case specific reasons why.

**Date (under Participant Signature line):** Write the month, day, and year the participant signed the ISP Supports and Services Authorization form on this line.

**Guardian Signature Line:** The guardian’s signature on the ISP Supports and Services Authorization page indicates the guardian’s request for identified services on behalf of the participant. In the event the guardian is not physically present at the person centered planning (PCP) meeting, documentation must exist that verifies the plan developer forwarded a copy of the entire ISP Supports and Services Authorization form to the guardian for review.

If a plan developer is unable to obtain the guardian’s signature before submitting the ISP Supports and Services Authorization form for authorization, the plan developer has the option of obtaining confirmation from the guardian by e-mail or telephone that they agree with the plan. The plan developer must then document in the guardian signature section the guardian’s approval of the plan, the means by which the plan developer received approval from the guardian (e-mail or telephone), and the date the approval was received.

Although the ISP Supports and Services Authorization form can be submitted for authorization without the guardian’s signature when the above mentioned documentation is present, the plan developer must still require the guardian to sign, initial, and forward a copy of the ISP Supports and Services Authorization form to the plan developer by mail or fax to support the request for services. The plan developer must then maintain the ISP Supports and Services Authorization form signed and initialed by the guardian in the participant’s file for quality assurance review purposes.

**Date (under Guardian Signature line):** Write the month, day, and year the guardian signed the ISP Supports and Services Authorization form or the month, day, and year the guardian gave confirmation by e-mail or telephone of their agreement with the ISP on this line.

**Plan Developer Signature Line:** The plan developer must sign here.

**Date (under Plan Developer Signature line):** Write the month, day, and year the plan developer signed the ISP Supports and Services Authorization form on this line.

**Plan Developer Acknowledgement (\*\*):** By signing this page, the plan developer acknowledges that any modifications to the Individual Support Plan (ISP) that was initially developed by the person-centered planning team will only be made with the agreement of the participant, guardian, and any applicable providers.

# Supports and Services Authorization Form

## EXAMPLE FORM

**Participant Name:** Jonathon Andrews

**Medicaid ID#:** XXXXXXXX

<b>Initial Plan</b> <input checked="" type="checkbox"/> <b>Annual</b> <input type="checkbox"/>	<b>DD Waiver Participant?</b> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
<b>Plan Developer:</b> Susan Pike	<b>Plan Developer Agency and Address:</b> XYZ Service Coordination    1985 Broadway, Boise, ID 83706

**DD Waiver Participant/Guardian Initials:** \_\_\_\_\_ I have been informed of and understand my choice of waiver services. I choose to receive waiver services rather than to accept placement in an ICF/MR. I understand that I may, at any time, choose facility admission.

Service Provider	Service Type	Proposed Start Date and End Date	Service Code	Units & Frequency of Service (#/day/week/month)	Unit Cost (\$/hr/day)	Annual Cost	IPA # This column for department use only
<b>WAIVER</b>							
ABC Agency	Agency Affiliation	1/1/09 12/31/09	0919B	365 units/year	7.96/day	2,905.40	
ABC Agency	Certified Family Home	1/1/09 12/31/09	S5140-U8	365 units per year	53.39/day	19,487.35	
ABC Agency	Hourly Supported Living	1/1/09 12/31/09	H2015-U8	160 units per week	3.24/unit	26956.80	
EFG Developmental	Adult Day Care	1/1/09 12/31/09	S5100-U8	16 units per month	1.50/unit	288.00	
LMNOP Transportation	Non-Medical Transportation	1/1/09 12/31/09	A0080-U8	8 units per week	.44/unit	183.04	
EFG Developmental	Supported Employment	1/1/09 12/31/09	H2023-U8	24 units per week	5.25/unit	6552.00	
QRS Services	Behavioral Consultation	1/1/09 12/31/09	H2019-U8	8 units/month	6.42/unit	616.32	
QRS Services	Nursing	1/1/09 12/31/09	T1001-U8 TD	1 unit/month	44.49/unit	533.88	

**STATE PLAN**

XYZ Service Coordination	Plan Development	11/1/08 12/31/09	G9007	48 units per year	10.00/unit	480.00	
XYZ Service Coordination	Plan Monitoring	1/1/09 12/31/09	G9012	32 units per year	10.00/unit	320.00	
XYZ Service Coordination	Service Coordination	1/1/09 12/31/09	G9002	1 unit/month	108.33/unit	1299.96	
EFG Developmental	Developmental Therapy - Ind Cntr	1/1/09 12/31/09	H2032	16 units per week	4.53/unit	3768.96	
EFG Developmental	Developmental Therapy – Grp Cntr	1/1/09 12/31/09	H2032HQ	14 units per week	1.80/unit	1310.40	
EFG Developmental	Developmental Therapy – Ind Comm	1/1/09 12/31/09	97537	32 units per week	5.01/unit	8336.64	
QRS Services	Supportive Counseling	1/1/09 12/31/09	H0004-HM	2 units/week	8.00/unit	832.00	
QRS Services	DME- gloves	1/1/09 12/31/09		2 boxes/month	10.00/box	240.00	
Healthy Steps	Psychosocial Rehabilitation	1/1/09 12/31/09	H2017	4 units per week	11.35/unit	2360.80	

Assigned Budget Amount: \$XXXXXXX

Medicaid Annual Total: \$XXXXXXX

Authorization is requested for the services listed above by the following people:

\_\_\_\_\_  
PARTICIPANT SIGNATURE\_\_\_\_\_  
GUARDIAN SIGNATURE (if applicable)\_\_\_\_\_  
PLAN DEVELOPER SIGNATURE\_\_\_\_\_  
DATE\_\_\_\_\_  
DATE\_\_\_\_\_  
DATE

\*\*By signing this page, I am acknowledging as the plan developer that any modifications to the Individual Support Plan (ISP) that was initially developed by the person-centered planning team will only be made with the agreement of the participant/guardian and/or any applicable providers.

## Signature Page Instructions and Form

**Note:** This form is provided as an example and can not be used as an actual ISP authorization page.

**Participant Name:** Type the name of the participant exactly as it appears on their Idaho Medicaid card.

**Medicaid #:** Type the first seven digits of the participant's Medicaid identification number as listed on their Idaho Medicaid card.

**Date of Person Centered Planning Meeting (PCP):** Type the month, day, and year the PCP meeting was conducted.

**Initial Plan:** Check this box if this is the first Individual Support Plan (ISP) being submitted for the participant.

**Annual:** If this is not an initial plan, check this box.

**Address:** Type the participant's current physical address with city, state, and ZIP code.

**Telephone #:** Type the telephone number where the participant can be reached. Designate if the number is for a landline, a cell phone, or a message phone.

**Date of Birth:** Type the participant's date of birth with month, day, and year.

**Gender:** Check the box for the participant's gender.

**Guardian Name (if applicable):** Type the first and last name of the participant's legal guardian or "Self" if the participant is the guardian.

**Note:** If a participant is committed to the Department of Health and Welfare, indicate that the department is the guardian.

**Guardian Address:** Type the guardian's current mailing address with city, state, and ZIP code.

**Guardian Phone #:** Type the guardian's phone number with the area code.

**Note:** If a guardian is named, verify that a copy of the guardianship papers is on file with the Idaho Center for Disabilities Evaluation (ICDE). If not, obtain the guardianship papers and submit them to the Idaho Center for Disabilities Evaluation (ICDE).

**Emergency Contact (if applicable):** If no legal guardian is identified, type the name, address, and telephone number of a family member or friend who can be contacted in the event of an emergency.

**Plan Developer:** Type the first and last name of the plan developer.

**Plan Developer Agency and Address:** Type the agency's name and mailing address where the plan developer is employed with city, state, and ZIP code.

**Plan Developer Telephone #:** Type the telephone number where the plan developer can be reached.

**Participant Signature:** The participant must sign (or mark or stamp) here. If the participant is unable or unwilling to sign due to "individual special circumstances" (e.g., refusal to sign at that time, participant is tactile defensive), the plan developer must document the case specific reasons why.

**Did You Attend your Person Centered Planning (PCP) Meeting?:** The participant must indicate whether or not they attended their person centered planning meeting by checking the appropriate box. If the participant checks "YES", the plan developer must include a brief summary of how the participant participated in the process in the Current Status section of the ISP. If the participant checks "NO", the plan developer must provide information on how the participant participated in the process (e.g., discussion at another time).

**Planning Team Member Signatures:** Individuals who are physically present at the PCP meeting must sign here.

**Did You Attend the Person Centered Planning (PCP) Meeting?:** All members of the planning team must indicate whether or not they attended the PCP meeting by checking the appropriate box.

**Relationship to Participant:** Each PCP team member must legibly print the nature of their relationship to the participant whether it be a member of the PCP team or a service provider (i.e. mother, developmental specialist, program coordinator, etc.). If the PCP team member is a service provider, have them also indicate their agency name in this section.

**Other Planning Team Members:** List the first and last name of individuals whose input was considered when developing the plan but who were not physically present at the PCP meeting.

**Relationship to Participant:** The plan developer must indicate the nature of the other planning team members' relationship to the participant. If a team member is a service provider, indicate their job title and agency name.

**Idaho Department of Health and Welfare**  
**INDIVIDUAL SUPPORT PLAN**  
**EXAMPLE FORM**

For individuals living in Certified Family Homes, this ISP meets the requirements of a Negotiated Service Agreement in Certified Family Home rules, IDAPA 16.03.19, when accompanied by a current "Health and Well-Being Form" and Residential Habilitation Implementation Plan(s).

**Participant Name:** Jonathon Andrews

**Medicaid #:** XXXXXXXX

**Date of Person Centered Planning (PCP) meeting:**

Initial Plan ☒

Annual ☐

<b>Participant Address and Phone #:</b> 001 Main Street Boise ID 83702  (208) 123-4567  <b>Participant Date of Birth:</b> 5/5/1955  <b>Gender:</b> M <input checked="" type="checkbox"/> F <input type="checkbox"/>	<b>Guardian Name (if applicable), Address, and Phone #:</b> Self  <b>Emergency Contact (if applicable):</b> Deena Little (sister) (208) 891-0123	<b>Plan Developer:</b> Susan Pike  <b>Plan Developer Agency and Address:</b> XYZ Service Coordination 1985 Broadway, Boise ID 83706 <b>Plan Developer Telephone#:</b> (208) 987-6543		
<b>Person Centered Planning Team Members</b>				
<b>Participant Signature:</b> <i>Jonathan Andrews</i>		<b>Did you attend your Person Centered Planning meeting?</b> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
<b>Planning Team Member Signatures</b>	<b>Did you attend the PCP meeting?</b>	<b>Relationship to Participant</b>	<b>Other Planning Team Members</b>	<b>Relationship to Participant</b>
<i>Susan Pike</i>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Plan developer/TSC- XYZ Service Coordination	Dan Jones	Van Driver- LMNOP Trans.
<i>Deborah Smith</i>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Mother/Provider	Scott Nelson	Nurse-QRS Services
<i>Deena Little</i>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Sister	Brenda Wilson	PSR worker- Healthy Steps
<i>JoAnn Davis</i>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Program Coordinator- ABC Agency		
<i>Devan Miller</i>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Developmental Specialist- EFG Developmental		
<i>Lisa Roberts</i>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Job coach- EFG Developmental		

## Personal Summary Instructions and Form

**Participant Name:** Type the name of the participant exactly as it appears on their Idaho Medicaid card.

**Current Status Instructions:** Describe each of the following areas using a strengths based approach, as applicable and note deficit or need areas, as applicable. A deficit may not necessarily be a need.

- **Participant Involvement in the Person Centered Planning (PCP) Process:** Describe how the participant participated in the PCP process. Include a brief summary of statements and choices made regarding their services.
- **Physical/Mental Health:** Identify primary and co-occurring diagnoses and health conditions (e.g., high blood pressure, allergies, specialized medical equipment, bipolar disorder, treatments).
- **Living Situation:** Describe the participant's current living situation (e.g., in own home/apartment with or without roommates, certified family home with or without relative providers, residential assisted living facilities (RALF), activities of daily living, housekeeping skills).
- **Family/Social Relationships:** Identify family members or natural supports who are involved in the participant's personal life.
- **Behavioral Issues:** Identify behaviors that impact the participant's health and safety and the safety of others in the community.
- **Employment:** Identify where the participant works, what the participant does, and whether it is paid or unpaid employment. Identify if the participant is interested in employment.
- **Legal Status:** Specify whether a participant is the guardian or has a guardian. If a Durable Power of Attorney for Health Care has been assigned for the participant, please indicate the first and last name of the individual who has Durable Power of Attorney for Health Care for the participant and a contact telephone number.
- **Communication:** Indicate the participant's primary method of communication (e.g., verbal, sign language, communication devices, interpretive services) and skills in expressive/receptive language.
- **Ambulation/Mobility:** Indicate what adaptive equipment is necessary for mobility and what methods the participant uses to navigate through the community (e.g., bicycle, public transportation, drives own car, motorized wheelchair).
- **Financial Status:** Indicate if the participant has a representative payee or conservatorship, trusts, personal checking and/or savings account(s), sources of income, and the participant's ability to manage funds or if assistance is required.
- **Community Access and Other:** Identify where the participant accesses the community, interests of the participant and any other information here.

**Assessed Need(s) Definition:** An assessed need is identified through documented, professional, objective observation and testing. It is relevant to the participant's current situation and is determined by identifying which assessed deficits are necessities based on information that they impact or are barriers to the participant's independence. Assessed needs can be remedied through the use of available supports and services. They are skills the participant needs help with, not services they are to receive.

**Correlate Assessed Needs to Goals to be Addressed Within the Plan Year:** After identifying the assessed needs of the participant as identified in the Personal Summary and other assessment tools, list them in the table; one per line, with a number. These do not have to be prioritized. For each assessed need that will be addressed during the plan year, a direct relationship must always exist between each of them and the short-term participant goals and provider based goals listed on the Individual Support Plan (ISP) Supports and Services page(s).

## **Additional Information Related to the Personal Summary Form**

**Transition Plans and Goals** - The transition plan is the process that is anticipated to meet the transition goal. It must facilitate independence, personal goals, and personal interests while helping the participant move toward fewer paid services and greater natural supports in community environments. The transition plan must include a transition into one or more of the following environments:

- An alternative setting
- Vocational training
- Supported or independent employment
- Volunteer opportunities
- Community based organizations and activities
- Less restrictive settings

There are **only two instances** when a transition plan is required for a participant:

- A transition plan must be developed and included on the ISP when a participant has been notified that they are borderline eligible for waiver **or** state plan services at the beginning of the plan year on their eligibility notice.
- A transition plan must be developed when a participant is anticipated to transition to a lower intensity or frequency of any service they receive during the upcoming plan year.

The transition plan is incorporated on the Personal Summary page of the ISP. The criteria in which a transition plan is required are stated on the form, as are the accepted transition areas.

- For **all** participants, mark the appropriate box indicating if a transition plan is needed.
- If a transition plan is required:
  - As a PCP team, discuss and write in the first column which transition area(s) are anticipated for the participant.
  - Assign each area with a number for purposes of tracking across the table.
  - In the second column, write the transition goal and planning steps for the identified transition area within the plan year. These goals and planning steps should be structured and progressive  
**Examples:** a reduction in the amount of hours of a more restrictive service, increase in time alone or with natural supports for supervision, use of other non-Medicaid funded resources, etc.
  - In the third column, write who is going to ensure the goal and steps are accomplished for each transition area.
  - In the fourth column, write the expected completion date for each transition area.  
**Note:** The plan monitor should document in their Plan Monitoring notes the progress made toward each transition area when an addendum is not needed (e.g., increase in volunteer hours). These notes can be helpful when completing the Plan Monitor Status Summary.

- For those transition steps where a service is decreased or discontinued and the annual budget is affected, **submit an addendum.**

**Note:** The plan monitor should document on the 6-month Plan Monitor Status Summary the progress made in each transition area.

- If the PCP team determines the participant needs a behavior/safety plan for one of the goals and planning steps, write “Refer to attached \_\_\_\_\_ plan”.
- For participants who are moving out on their own or getting off probation, they still need to meet the criteria to have a transition plan.
- If the participant is expected to move between hubs or regions during the plan year, refer to the Transfer Protocol on the Developmental Disability (DD) Care Management Web site.
- Unexpected transitions throughout the year can be handled with an addendum, if necessary.

**Safety Plans** - A safety plan should be in place in the event that the participant requires immediate help at a time when a paid support is not available. A safety plan is needed when any of the following criteria are met:

- A “YES” answer for the following question on the Health and Well-Being Checklist is identified **and** the participant lives in a certified family home or supported living environment:
  - #4 “Within the last plan year have there been any situations that could re-occur that would put the participant or others in danger?” If a ‘yes’ response, a safety plan is required.
- Any requests for home alone time on an ISP (certified family home or supported living only).
- There is a transition to fewer paid supports indicated by a ‘yes’ for either situation on the transition section of the ISP. (For example, a participant moving from ‘Intense’ to ‘High’ or ‘High’ to ‘Hourly’)

A safety plan generally includes the availability of natural supports and other paid supports or devices such as:

- Co-workers at a job site
- Roommate or neighbors at home
- Family, friends and good community acquaintances
- A Personal Emergency Response System (PERS)

A safety plan should answer, at a minimum, the following questions:

- What support is in place to reduce the risk?
- What will be done to resolve a risk due to loss of supports?
- How has the participant demonstrated their ability to implement any part of the identified safety plan?

Supporting documentation such as staffing schedules, activity schedules, progress notes, and incident reports may be necessary to determine if the safety plan is adequate.

**Idaho Department of Health and Welfare**  
**Personal Summary Form**  
**(Including Current Status, Assessed Needs, and Transition Planning)**  
**EXAMPLE FORM**

**Participant Name:** Jonathon Andrews

**Current Status:** Using a strengths-based approach, describe the individual in each of the following areas that apply and indicate natural supports that the participant has.

**Participant Involvement in the PCP process:** Jonathan identified who he wanted at his PCP meeting. While at the meeting, Jonathan stated that he wants to keep his job at McDonald's but not have a job coach all the time. Jonathan stated he enjoyed his DDA hours and the activities he does there. He agreed that he needs some work on not injuring himself and stated he wants to work harder on that this year. Jonathan also stated he wanted to go camping with his friend, George, sometime this year.

**Physical/Mental Health:** Jonathan has a diagnosis of moderate mental retardation as a result of complications at birth. Jonathan was in an accident when he was 20 years old that has caused seizure activity and some decreased mobility in his right side. He also has asthma and GERD, for which he takes medication. Jonathan has also been diagnosed with Bipolar Disorder which he also takes medication for and accesses PSR services to address coping skills.

**Living Situation:** Jonathan currently lives with his mother, Deborah Smith, in Boise. Jonathan receives supported living services to increase his independence in the home.

**Family/Social Relationships:** Jonathan spends one weekend a month at his sister's (Deena) house with her husband and children (natural supports). He also goes camping with them.

**Behavioral Issues:** Jonathan values his independence and does not respond when told what to do. Jonathan will sometimes hit others when asked to do something he does not want to do. Jonathan does engage in self-injurious behaviors such as biting and scratching himself when he is upset. He may also display repetitive behaviors such as rocking, which providers have indicated will decrease when ignored. Jonathan prefers time alone when he is upset to cool down. Jonathan responds best to positive reinforcement when he does well and behaves appropriately. He is task-oriented and likes to stay busy, which decreases negative behaviors.

**Employment:** Jonathan has a job at McDonald's cleaning the lobby area. He uses a job coach to help him move from task to task and maintain his employment.

**Legal Status:** Jonathan is his own guardian.

**Communication:** Jonathan is verbal but currently has difficulty with receptive and expressive communication skills.

**Ambulation/Mobility:** Jonathan is fully ambulatory, however, he does have decreased mobility on his right side due to seizure activity. This is not an area of need as Jonathan will ask for assistance if needed.

**Financial Status:** Jonathan's mother, Deborah, is his representative payee as he has difficulty with money concepts. Jonathan does want to work toward assisting in managing his own money.

**Community Access and Other (include interests here):** Jonathan enjoys listening to the radio, watching old western movies and visiting Cold Stone Creamery. He also likes to look at magazines and cut out the pictures. Jonathan also participates in Special Olympics bowling and likes to call his friend George from his bowling league on Wednesday evenings (natural support).

**Participant Name:** Jonathan Andrews **Review the ICDE assessments, current status, and provider evaluation tools to identify the participant's assessed needs. Each assessed need below must have a one year goal identified on the supports and services page(s) of the ISP.**

ASSESSED NEED	
1. Managing general medical conditions	8.
2. Increasing daily living skills	9.
3. Increasing social and communication skills	10.
4. Managing finances	11.
5. Managing problem behaviors	12.
6. Maintaining employment	13.
7. Managing mental health	14.

**TRANSITION PLANNING: A transition plan must facilitate independence, personal goals and personal interests while assisting the participant to move toward fewer paid services and greater natural supports in community environments. The transition plan must also meet the health and safety needs of the participant.**

Based on the eligibility notice, is this participant borderline eligible for waiver or state plan services at the beginning of the plan year? **Yes** ☒ **No** ☐

Based on assessed needs, is this a participant who will need to transition to a lower intensity/frequency of any services they will receive during the upcoming plan year?

**Yes** ☐ **No** ☒

If either question is marked "Yes", describe the transition plan below in terms of where and how the transition will take place: It must be a transition into one or more of the following: An alternative setting, vocational training, Supported or independent employment, volunteer opportunities, community based organizations and activities and/or less restrictive setting.

Transition area	Goal & Planning steps (reduction of services)	Responsible Party	Expected Completion Date
1. Less restrictive setting	1. Reduce use of Supported living: A. Allow alone time beginning now for 4 hours during night. B. Increase activities with George C. Add visiting mom 1 weekend a month D. Hire laundry/housekeeping service 1x/wk	1. Jonathan, RH, TSC, George, mom	1. 7-1-09
2. Community based organizations and activities	2. Increase community activities alone: A. Get/learn to use a bus pass to go to work, ColdStone, Bowling, SO, ARC, and grocery store. B. Set up time to go alone to the ARC where planned activities are taking place 2 hours a day 3 days a week	2. Jonathan, TSC, RH, mom	2. 10-1-09
3. Volunteer opportunities	3. Increase volunteer opportunities A. Volunteer at ColdStone (work up to 3 mornings/week, 2 hours each) *See attached safety plan	3. Jonathan, TSC, Coldstone, RH	3. 4-1-09
4. Supported/ind. Emp.	4. Increase hours at work. A. Use a checklist & timer for independent guidance B. Ask co-workers for feedback on quality C. Access Medicaid work incentive program for maintaining Medicaid while working	4. Jonathan, CSE Supervisor, TSC	4. 11-1-09

## Supports and Services Instructions and Form

**Note:** This form is provided as an example and is not representative of actual ISP Support and Services pages. The services below are not intended to be a comprehensive list. For services not listed here, refer to the rate chart.

**Name:** Type the name of the participant exactly as it appears on the Idaho Medicaid card.

**Supports and Services column:** List in this column all of the supports and services that will be delivered to the participant during the plan year.

Some of the services listed in this column provide supports that have the participant's responsibilities and expectations listed in IDAPA code or their Provider Agreement and do not need to be copied here. These services include (see example Individual Support Plan (ISP) pages):

- Residential habilitation - supported living agency - include emergency number
- Plan development

Some of these services have goals that do not have measurable participant objectives associated with them. These supports are accomplished by the provider. If the participant receives any of the following services, please include a list of the supports being provided as well (see example ISP pages):

Service	Support to be listed
Residential Habilitation – Certified Family Home Affiliation Agency	Specific goals of the provider and emergency number
Residential Habilitation Certified Family Home**	Supports of the home, frequency of doctor and dentist visits, and if alternate care is in place
Adult Day Care**	Supports of the provider
Transportation	Pick up site and ending destination including agency name, address, and city
Behavioral Consultation**	Supports of the provider
DD Waiver Nursing services**	Goals of the provider from their care plan
Durable Medical Equipment (DME)	Supplies/items
Plan Monitoring	Indicate face to face contact at least every 90 days
Service Coordination and Emergency Plan	Specific goals of the provider, frequency/mode of contact/who is being contacted, emergency and non-emergency situations
Supportive Counseling**	Supports of the provider
Psychosocial Rehabilitation	Goals of the provider from their treatment plan - double check there is no duplication with other services (16.03.10.513.04)
Natural Supports	Locations in the community that are accessed
Collateral Contact	Goal(s) of the provider

\*\* These services need to be documented with data and/or a narrative on the Plan Monitor Status Summary at the 6 month time frame.

Lesser used services such as chore services, respite, home modifications, specialized medical equipment, personal emergency response systems (PERS), home delivered meals, medication management, social history, and interpretation can be listed in the Supports and Services column, along with the frequency and provider in the appropriate columns.

**Goals to be Addressed Within the Plan Year column:** Based on assessed needs, include in this column any short-term goals that the participant will work to accomplish within the plan year for the following service types:

- Residential Habilitation Certified Family Home (CFH)
- Residential Habilitation Supported Living
- Community Supported Employment (CSE)
- Developmental Therapy

Each goal must be given a number to match the assessed need from the Assessed Need box on the Personal Summary page. These goals and their service type **must** be documented on the Plan Monitor Status Summary at the 6-month timeframe.

**Note:** The assessed need numbering system (1, 2, 3...) must continue throughout the ISP Supports and Services form and any subsequent addendums. In other words, make sure the number used to identify any goal(s) requested on an ISP or addendum matches the number of the assessed need it correlates to.

Measurable objectives are only listed on a participant's Implementation Plan. The Idaho Center for Disabilities Evaluation (ICDE) may request other documentation for clarification if the goals on the Supports and Services page are too broad and/or appear to be duplicative.

**Frequency Column:** Identify how often each service or support is being delivered (e.g., daily, 10 hours/day, 20 hours/week, 5 days/week, 2 times/month, 1 time/year, 50 miles/week).

- For durable medical equipment (DME), identify the quantity of the product (e.g., 3 boxes). If the product is also being requested on a regular basis (e.g., weekly, monthly), this information must also be included (e.g., 3 boxes per week, 1 case per month).
- For developmental therapy, identify whether it is home and community-based individual, home and community-based group, center-based individual, or center-based group developmental therapy.
- For transportation, include the miles per trip, trips per day, and the number of days per week it is occurring (e.g., 4 miles/ trip x 2 trips/day x 3days /wk).
- For natural supports, include the frequency the activities are completed.
- For the emergency plan, include the frequency, as needed.

**Agency or Provider Column:**

- Type the name of the provider, if the participant receives CFH services.
- Type the agency responsible for providing the service and/or support (do not include staff names).
- Type the name of the person or organization responsible for helping the participant during an emergency or for natural supports.

**Idaho Department of Health and Welfare**  
**Supports and Services Form**  
**EXAMPLE FORM**

**Participant Name: Jonathon Andrews**

**Identify in the grid below the goals to be addressed within the plan year using the number associated with the correlating assessed need from the Assessed Needs box on the Personal Summary page.**

<b>Supports and Services</b>	<b>Goals to be Addressed Within Plan Year</b>	<b>Frequency</b>	<b>Agency or Provider</b>
<b>Residential Habilitation Agency-Affiliation</b> Emergency contact number: 111-1111 -Attend PCP meetings as needed during plan year -Develop implementation plans and revise as needed to meet skill needs -Face to face contact with affiliate provider at least quarterly -Training of affiliate provider to meet participant needs (including behavior) -Assist in meeting annual certification needs		365 days/year	ABC Agency
<b>Residential Habilitation (CFH)</b> -See Dr. Johnson (physician) 1x/ year -See Dr. White (dentist) 2x/ year -Assist with medications -Assist with scheduling appointments and transportation -Assist with daily living skills -Assist with finances -Home Alone Time up to 7 hours per week -Assist with recreational opportunities Alternate Care: None	Jonathan: 1.Will initiate taking medications 2.Will increase independence with bathing skills 3.Will increase social skills during meals 2.Will increase shopping skills 2. Will increase budgeting skills 2.Will increase opportunities for community integration 2.Will pick up own place and setting after meals	365 days/year	Deborah Smith, Provider  ABC Agency
<b>Residential Habilitation- Supported Living</b>  Emergency contact number: 111-1111	Jonathan: 1.Will initiate taking medications 2.Will increase independence with bathing skills 3.Will increase social skills during meals 2.Will increase shopping skills	40 hours per week	ABC Agency

<b>Supports and Services</b>	<b>Goals to be Addressed Within Plan Year</b>	<b>Frequency</b>	<b>Agency or Provider</b>
	<b>2.</b> Will increase budgeting skills <b>2.</b> Will increase opportunities for community integration <b>2.</b> Will pick up own place and setting after meals		
<b>Adult Day Care</b> <b>2.</b> Assist with ADLs <b>3.</b> Monitor social opportunities <b>3.</b> Provide recreational activities		4 hours/month	EFG Developmental
<b>Non-Medical Transportation</b> From home to EFG Developmental (234 Foothill St. Boise) and back		1 mi/trip 2 trips/day 4 days/wk	LMNOP Transportation
<b>Community Supported Employment- Job Coaching</b>	Jonathan: <b>6.</b> Will initiate obtaining work materials <b>6.</b> Will stay on task <b>6.</b> Will communicate with supervisor <b>6.</b> Will seek assistance when needed	6 hours/week	EFG Developmental
<b>Behavioral Consultation</b> <b>5.</b> Provide staff training <b>5.</b> Provide emergency back-up as needed <b>5.</b> Consult with direct care staff regarding behavior management techniques		2 hours/month	QRS Services
<b>Nursing</b> <b>1.</b> Monitor prescription needs <b>1.</b> Monitor dietary needs <b>1.</b> Monitor blood pressure		1 visit/month	QRS Services
<b>DME-gloves</b>		2 boxes/ month	QRS Services
<b>Plan Development</b>		12 hours/year	XYZ Service Coordination
<b>Plan Monitoring</b> -Have face to face contact with Jonathan at least every 90 days		8 hours/year	XYZ Service Coordination
<b>Service Coordination</b> -Assist with Healthy Connections paperwork -Explore guardianship process -Explore alternative care -Link to Special Olympics events in the		At least 1x every 30 days	XYZ Service Coordination

Supports and Services	Goals to be Addressed Within Plan Year	Frequency	Agency or Provider
<p>area</p> <p>- By phone or in person contact: Jonathan, mom, relevant providers, etc.</p> <p><b>Emergency Plan</b>  <b>-In the event of a medical emergency:</b> Contact 911, and call Jonathan's mother Deborah at 123-4567.  <b>-In the event of a non-medical emergency:</b> Contact Deborah at 123-4567, sister Deena at 891-0213. Susan Pike can be contacted at 987-6543</p>		<p>As needed</p> <p>As needed</p>	<p>911</p> <p>Deborah Smith</p> <p>Deena Little</p> <p>XYZ Service Coordination</p>
<b>DDA</b>	<p>Jonathan:</p> <p>3. Will increase communication by using full sentences</p> <p>3. Will request assistance from store employees</p> <p>3. Will stay on topic in conversations</p> <p>3. Will follow multiple part instructions</p> <p>4. Will learn to make change using bills and coins</p> <p>4. Will learn to write a complete check</p> <p>4. Will learn to maintain an accurate check book</p> <p>2. Will tell time on a clock</p>	<p>Ind/Cntr 4 hours/ week</p> <p>Grp/Cntr 3.5 hours/ week</p> <p>Ind/Comm 8 hours/ week</p>	EFG Developmental
<p><b>Supportive Counseling</b></p> <p>5. Provide assistance in problem solving</p> <p>3. Provide assistance with interpersonal relationships</p>		30 minutes/week	QRS Services
<p><b>Psychosocial Rehabilitation</b></p> <p>7. Provide training to build and maintain stabilization in mood, behavior</p> <p>7. Provide training to use medical resources appropriately</p>		1 hour/week	Healthy Steps
<p><b>Natural Supports</b></p> <p>-Church</p> <p>-Spend time with family</p> <p>-Special Olympics bowling</p>		<p>Every Sunday</p> <p>1 wknd a mo.</p> <p>Weekly</p>	<p>Deborah Smith</p> <p>Deena Little</p> <p>Deena Little, George</p>

## Supports and Services Addendum Instructions and Form

**Participant Name:** Type the name of the participant exactly as it appears on the Idaho Medicaid card.

**Medicaid ID#:** Type the first seven digits of the participant's Medicaid identification number as listed on the Idaho Medicaid card.

**DD Waiver Participant:** Check the "Yes" or "No" box to indicate whether the participant is receiving developmental disability (DD) waiver services.

**Current ISP Start Date:** Type the month, day, and year the Individual Support Plan (ISP) was authorized for which an addendum is being submitted.

**Date Addendum Requested:** Type the month, day, and year the ISP Supports and Services Addendum form is completed.

**Plan Developer:** Type the plan developer's first and last name.

**Plan Developer Agency and Address:** Type the agency name and mailing address where the plan developer is employed with city, state, and ZIP code.

**Provider Requesting Addendum:** Type the name of the individual who is requesting the addendum on this line, if it is someone other than the plan developer.

**Reason for Addendum Request:** Identify which of the options listed below is the reason for submitting the addendum.

**Note:** The reason must be based on the participant's need or want and must be clearly identified. More than one option can be listed. **Additional pages can be attached when justification is needed.**

- Adding or deleting goals identified on the ISP Supports and Services form.
- Adding or deleting services (e.g., supported living, community supported employment, DDA).
- Changing the type of service (e.g., group vs. individual).
- Changing the amount of service.
- Changing the agency identified on the ISP Supports and Services form.

**Check this box if the addendum is for change of participant name, guardian, address, and/or telephone number *only* and add new information below:** When submitting an addendum for a participant change of name (accompanied by legal documentation), guardian (accompanied by documentation), marital status, address, or telephone number, check this box and fill in the new information in the space provided.

**Service Provider Column:** Type the name of the provider or agency responsible for delivering the service.

**Service Type Column:** Type the service delivered by the service provider (e.g., adult day care, supportive counseling).

**Goals to be Addressed Within the Plan Year Column:** Indicate in this column the changes being made for each support or service included on the addendum. This could include an increase or decrease in hours of service, addition or deletion of goals, etc. Each goal listed on the addendum must be given a number to match an assessed need from the Assessed Need box on the Personal Summary page.

**Proposed Start and End Date Column:** Type the proposed start and end date for each service delivered. Most often the end date is the last day of the annual plan.

**Service Code:** Refer to pages 6 and 7 of this manual to determine the service code.

**Frequency and Unit Costs:** Refer to pages 6 and 7 of this manual to determine the new totals.

**Requires IPA # Column:** This column is for Department of Health and Welfare use only. If the box for the “Service Type” contains a number, the service has been prior authorized.

**Previous Medicaid Annual Total Line:** List the “Previous Annual Medicaid Annual Cost” from the existing ISP or the most recent addendum.

**Addendum Subtotal Line:** List the subtotal cost of all services requested on the addendum.

**Note:** When discontinuing a service, be sure to subtract the cost of the discontinued service.

**Assigned Budget Amount:** Type the assigned budget amount from the participant’s Eligibility Notice. Do an Extenuating Circumstance form if the addendum puts the amount of services over the assigned budget.

**New Medicaid Annual Total Line:** Add or subtract the “Addendum Subtotal” from the “Previous Medicaid Annual Total”.

**Participant Signature Line:** The participant must sign (or mark or stamp) here if the participant is the guardian. If the participant is unwilling or unable to sign due to “special circumstances” (e.g., refusal to sign at that time, participant is tactile defensive), the plan developer must document the case specific reasons why.

**Date (Under Participant Signature Line):** Write the month, day, and year the participant signed the ISP Supports and Services Addendum.

**Guardian Signature Line:** Refer to page 7 of this manual for directions on how to get a guardian signature.

**Date (Under Guardian Signature Line):** Write the month, day, and year the guardian signed the ISP Supports and Services Addendum or the month, day, and year the guardian gave confirmation by e-mail or telephone of their agreement with the ISP Supports and Services Addendum.

**Plan Developer Signature Line:** The plan developer must sign here.

**Date (Under Plan Developer Signature Line):** Write the month, day, and year the plan developer signed the ISP Supports and Services Addendum.

**Plan Developer Acknowledgement and Signature(\*\*):** By signing this page, the plan developer is acknowledging that any modifications to the Individual Support Plan (ISP) that was initially developed by the person-centered planning team will only be made with the agreement of the participant/guardian and/or any applicable providers.

# Idaho Department of Health and Welfare Supports and Services Addendum Form

Region \_\_\_\_\_ Field Office \_\_\_\_\_  
 Addendum Start Date \_\_\_\_\_  
 Authorization Start Date \_\_\_\_\_  
 ISP end Date \_\_\_\_\_  
 DHW or DHW designee signature \_\_\_\_\_

Participant Name:

Medicaid ID#:

<b>DD Waiver Participant:</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>Current ISP Start Date:</b>	<b>Date Addendum Requested:</b>
<b>Plan Developer:</b>		<b>Plan Developer Agency and Address:</b>
<b>Provider Requesting Addendum:</b>		
<b>Reason for Addendum Request:</b>		

☐ ☒ Check this box if addendum is for change of name, guardian, address and/or telephone number **ONLY** and add new information below.

<b>New Participant Name:</b>	<b>New Participant Address (physical or mailing) and/or Phone Number:</b>
<b>New Guardian Name:</b>	<b>New Guardian Address (physical or mailing) and/or Phone Number:</b>

Service Provider	Service Type	Goal to Be Addressed Within Plan Year	Proposed Start and End Date	Service Code	Units & Frequency of Service (#/day/week/month)	Unit Cost (\$/hr/day)	Annual Cost (To be completed by PD)	IPA # This Column For Department Use Only
Previous Annual Medicaid Cost _____								
Addendum Sub-Total						\$		
Assigned Budget Amount			New Medicaid Annual Total			\$		

Authorization is requested for the services listed above by the following people:

---

PARTICIPANT SIGNATURE

---

GUARDIAN SIGNATURE (if applicable)

---

PLAN DEVELOPER SIGNATURE

---

DATE

---

DATE

---

DATE

**\*\*By signing this page, I am acknowledging as the plan developer that any modifications to the Individual Support Plan (ISP) that was initially developed by the person-centered planning team will only be made with the agreement of the participant/guardian and/or any applicable providers.**

## Plan Development Authorization Cover Sheet

<b>Date</b>	<b>Assessor</b>	<b>Participant</b>
<b>Prior Authorization Start Date</b> (Date provided by the plan developer)	<b>Prior Authorization End Date</b>	<b>MID #</b>
<b>Plan Developer and Agency Name: <i>(please print or type)</i></b>		<b>Provider Number (preferable):</b>

Agency Notes (if needed):

---



---



---



---

-----

### Plan Development Services Have Been Authorized: (for regional office use only)

Service	Frequency	Prior Authorization #
<b>G9007 Plan Development</b>	<b>hours / year</b>	

Department Notes (if needed):

---



---



---

**Instructions:** A template for the Plan Development Authorization Cover Sheet is sent by the IAP to the plan developer at the time of the annual notification; or the plan developer can retain a copy in file for use. The Plan Development Authorization Cover sheet can be completed at the time of the person centered planning meeting or after. It can be turned in directly to the Department of Health and Welfare for authorization. **The Prior Authorization Start Date should not be a day/month (date) earlier than last year's prior authorization date.**

## Health and Well-Being Checklist Instructions and Form

### DO NOT TURN THE INSTRUCTIONS IN WITH THE ISP

#### Why Use the Health and Well-Being Form

To ensure that protection from injury, illness, or fatality has been considered in all services and supports.

#### Purpose of the Health and Well-Being Form

The Health and Well-Being Form is a part of the Individual Support Plan (ISP) and is used to help plan developers determine whether health and safety needs can reasonably be met for adults receiving developmental disabilities services. While normal exposures to risks occur in any setting, efforts must be taken to reduce threats to a person's health and well-being. This form is to provide information on how a participant's health and well-being needs will be met.

#### Completing This Form

This form has eight question sections. Each section asks a "YES" or "NO" question. The area below each question directs you to comment further depending on your response. This form records procedures and responsibilities. It should be an accurate reflection of a participant's medical and health needs. It may be used as reference in an emergency. Spend time with this and make sure it is accurate.

#### Items Addressed on the ISP

Some items that may be referenced (such as behavioral programs, nursing services, items that have participant goals, or prior authorized waiver programs) on this form may also be addressed in some respect elsewhere within the ISP. To avoid duplication, specify the page reference in the notes below the related item. In all instances, information must be clear, be complete, not be contradictory to other parts of the plan, identify who is responsible, identify how needs will be met, and be easy to locate.

#### Immediate Response to an Allergic Reaction

Defined as medical or medication measures that a provider or natural support would take to make sure that the participant's life would not be in imminent danger (possible death within minutes). All person centered planning team members need to be aware of situations where an immediate response is necessary (e.g., Severe reaction to bee stings requiring immediate medication or medical action).

#### **The following definitions support the board of nursing rules at Title 23, Chapter 1, of Idaho Administrative Rules and Procedures Act (IDAPA), Rules of the Board of Nursing:**

A02. Administration of Medications: The process whereby a prescribed medication is given to a patient by one (1) of several routes. Administration of Medication is a complex nursing responsibility which requires a knowledge of anatomy, physiology, pathophysiology and pharmacology. Licensed nurses may administer medications and treatments as prescribed by health care providers authorized to prescribe medications.

A05. Assistance with Medication: Where permitted by law, after completion of a Board approved training program unlicensed assistive personnel in care settings may assist patients who cannot independently self administer medications, provided that:

- A plan of care has been developed by a licensed professional nurse; and
- The act has been delegated by a licensed nurse; and
- Written and oral instructions have been given to the unlicensed assistive personnel by a licensed nurse concerning the reason(s) for the medication, the dosage, expected effects, adverse reactions or side effects, and action to take in an emergency; and
- The medication is in the original pharmacy-dispensed container with proper label and directions or in an original over-the-counter container or the medication has been removed from the original container and placed in a unit container by a licensed nurse. Proper measuring devices must be available for liquid medication that is poured from a pharmacy-dispensed container. Inventories of any narcotic medications are to be maintained; and
- Any medication dosages not taken and the reasons thereof are recorded and reported to appropriate supervisory persons; and
- Assistance with medication may include: breaking a scored tablet, crushing a tablet, instilling eye, ear or nose drops, giving medication through a pre-mixed nebulizer inhaler or gastric (non nasogastric) tube, assisting with oral or topical medications and insertion of suppositories.

## Health and Well-Being Checklist

Participant Name: \_\_\_\_\_ MID#: \_\_\_\_\_ Date: \_\_\_\_\_  
 Plan Developer Signature: \_\_\_\_\_

If items are addressed further on the ISP, please clearly say so in the note section below each item.

These items were reviewed with providers and the participant/guardian and cross checked with information/applicable referrals on the History and Physical (if received)				
			<b>Yes</b>	<b>No</b>
<b>1. Is the participant able to self-administer medication?</b>				
If YES, who oversees this? If NO, how is it administered or who assists? Refer to guidelines as needed.				
<b>2. List all of the participant's medical and psychiatric conditions, medications and treatment (from current evaluations, assessments, prescriptions):</b>				
Medical and Psychiatric Conditions			Related Medications and Treatment	
Allergies	<b>Immediate Response</b> <b>Yes          No</b>		Medication and Treatment (if an immediate response is required, please specify)	
			<b>Yes</b>	<b>No</b>
<b>3. Does the participant have health and medical conditions that require on-going monitoring?</b>				
If YES, how is this need addressed and by whom?				
<b>4. Within the last plan year have there been any situations that could re-occur that would put the participant or others in danger?</b>				
If YES, how is this need addressed and by whom? <b>Include a safety plan for CFH/SL participants only</b>				
<b>5. Has there been a weight loss or gain that indicates nutritional or medical needs are not being met?</b>				
If YES, how is this need addressed and by whom?				
<b>6. Are skilled nursing or nursing oversight services required as indicated on the Medical Care Evaluation form (if received)?</b>				
If YES, how is this need addressed and by whom? (Include the delegation of any nursing services)				
<b>7. Are there structural, physical, emotional or environmental risks (e.g., evacuation during an emergency) that would present concerns related to the well-being of the participant?</b>				
If YES, how is this need addressed and by whom?				
<b>8. Are there significant health and well-being issues not addressed in the ISP or above?</b>				
If YES, name these and how is this need addressed and by whom?				

## Extenuating Circumstances Instructions and Form

### DO NOT TURN THE INSTRUCTIONS IN WITH THE ISP

If the requested services on the Individual Support Plan (ISP) or addendum exceed the participant's assigned budget, the person centered planning (PCP) team should:

- Evaluate all of the requested services to determine there are no natural supports or less costly services available to meet the participant's current assessed needs
- Make sure the need for additional/more costly services is based on one or more of the medical necessity criteria as follows:
  - a. It is reasonably calculated to prevent, diagnose or treat conditions in the participant that endanger life, cause pain, or cause functionally significant deformity or malfunctions.
  - b. There is no other equally effective course of treatment available or suitable for the participant requesting the service which is more conservative or substantially less costly.
  - c. Medical services shall be of a quality that meets professionally recognized standards of health care and shall be substantiated by records including evidence of such medical necessity and quality.

After the PCP team has evaluated the services, if the requested services still exceed the assigned budget, the plan developer should complete and submit the form with the annual plan or addendum to The Idaho Center for Disabilities Evaluation (ICDE) for review.

**Participant Name:** Type the name of the participant exactly as it appears on the Idaho Medicaid card.

**Medicaid #:** Type the first seven digits of the participant's Medicaid identification number as listed on the Idaho Medicaid card.

**Plan Start Date:** Type the month, day, and year of the start date of the current ISP.

**Primary Categories and Prompts:** Identify each of the applicable primary categories and prompts to specify the need for the request.

**What Options Were Considered to Stay Within Budget?** Include a list or brief narrative about what services were considered to stay within budget. If none are available, please explain.

**Narrative:** Complete a **concise** narrative describing the situation that requires an increase in service costs. It may be necessary to attach supporting documentation such as medical/mental health assessments, incident reports, or court/legal records. The documentation should be specific to time, frequency, and intensity of the need for additional funding. Give specific information about what is happening or changed in regard to:

- Behaviors
- Incidents
- Medical issues
- Mental health/psychiatric issues
- Functional issues

## Extenuating Circumstances

Participant Name: \_\_\_\_\_ MID #: \_\_\_\_\_

Plan Start Date: \_\_\_\_\_

<b>Primary Categories and Prompts (check all that apply)</b>		
<b>1. Behavioral Health/ Psychiatric:</b> <input type="checkbox"/> The behavior is of such intensity it poses danger <input type="checkbox"/> There is risk of victimization to others <input type="checkbox"/> There is a risk of inappropriate sexual behavior <input type="checkbox"/> There is a risk of violent or self injurious behavior <input type="checkbox"/> Symptom management difficulties(ability to manage psychiatric symptoms in their environment) <input type="checkbox"/> Other behavioral management problem in the community <input type="checkbox"/> Recent hospitalization/risk of hospitalization.	<b>2. Safety:</b> <input type="checkbox"/> Lack of ability to respond to emergencies <input type="checkbox"/> Structural, physical, or environmental barriers present concerns for well-being of consumer <input type="checkbox"/> Requires life support <input type="checkbox"/> Requires a personal emergency response system <input type="checkbox"/> Victimization <input type="checkbox"/> Other	<b>3. Residential Services for Adults With Developmental Disabilities:</b> <input type="checkbox"/> The participant requires 24 hour support in their home <input type="checkbox"/> Lower cost alternatives to the frequency and type are not available <input type="checkbox"/> Alternatives that would allow the participant to function with reduced or no supports for part of the day have been exhausted <input type="checkbox"/> Other <b>Supported Living Requests:</b> <input type="checkbox"/> Safety plan for persons meeting intense criteria that do not require 1-1 for twenty-four (24) hours. <input type="checkbox"/> Safety plan to maintain participant with high support (can be authorized following completion of the Transition Plan)
<b>4. Risk for Deterioration/ Loss of Skills:</b> <input type="checkbox"/> Reduction of services would result in reduced independence or loss of skills <input type="checkbox"/> Reduction of services would result in symptoms or conditions worsening <input type="checkbox"/> Reduction of services may lead to a more restrictive environment <input type="checkbox"/> Validate how this deterioration or loss of skills has been shown <input type="checkbox"/> Other	<b>5. Functional Limitations:</b> <input type="checkbox"/> Self Care – Basic living skills <input type="checkbox"/> Ability to understand <input type="checkbox"/> Ability to communicate <input type="checkbox"/> Learning <input type="checkbox"/> Mobility <input type="checkbox"/> Self-Direction <input type="checkbox"/> Economic Self – Sufficiency <input type="checkbox"/> Housing <input type="checkbox"/> Employment <input type="checkbox"/> Other	<b>6. Medical/ Physical Conditions:</b> <input type="checkbox"/> Confirm that the medical or physical condition requires continued treatment or follow-up and has significant impact on the individuals functioning. <input type="checkbox"/> Confirm that the ability to function at a normal level is decreased because of frequent exacerbations of medical or physical conditions. <input type="checkbox"/> Confirm that the functioning level of the individual is lower than the cognitive level would indicate because of the physical or medical condition. <input type="checkbox"/> Other
<b>7. Significant Co-Occurring Disorders: DD/MH/Substance Abuse/TBI</b> <input type="checkbox"/> Confirm that the co-occurring disorder would indicate a higher level of care than either one alone. <input type="checkbox"/> Other	<b>8. Court Ordered Treatment:</b> <input type="checkbox"/> Court ordered treatment. <input type="checkbox"/> Outpatient commitment <input type="checkbox"/> Treatment necessary to meet other conditions stipulated by the court.	<b>9. Homelessness:</b> <input type="checkbox"/> History of evictions <input type="checkbox"/> Unable to maintain housing <input type="checkbox"/> Other
<b>10. Transportation</b> <input type="checkbox"/> Closer services are not available <input type="checkbox"/> Less expensive forms of transportation are not available	<b>What Options Were Considered to Stay Within Budget?</b>	
<b>Narrative: CONCISELY describe how the participant's situation requires more paid services than has already been identified through assessment information.</b>		

## Plan Developer ISP Checklist

Participant Name:

Plan Developer Name:

Plan Due Date (30 days for initials/45 days before the expiration of the existing plan):

Date Submitted:

- ☐ ISP forms: Authorization Page, Signature Page, Personal Summary Page, Supports and Services Page(s)
  - ☐ Double-check History and Physical was received by ICDE
  - ☐ Check for participant/guardian/plan developer signatures
  - ☐ Waiver box initialed (\*) on Authorization Page
  - ☐ Goals are consistent with participant's assessed needs identified from Personal Summary/assessments
    - Participants who have serious general maladaptive behavior index scores (below -22) and/or criteria 2b. should have at least 1 formal goal to be addressed within the plan year
    - Participants who have a GMI of -17 in combination with their age equivalency of 8-8y6m should have objectives to address these issues
    - Participants who take prescription psycho-active drugs and who have Axis I diagnoses should have services or supports which address these issues.
  - ☐ Transition plan on Personal Summary for participants who are borderline waiver/state plan eligible as noted on their annual eligibility notice or are expected to need less intensity/frequency of supports during the year
  - ☐ Participant-based goals for Certified Family Home, Supported Living, CSE, Developmental Therapy are listed under "Goals to be Addressed with the Plan Year" on the Supports and Services page
    - Goals are specific enough to adequately determine what is being worked on and ensure there is no duplication of services. However they are not so specific as to list individual objectives, thereby requiring additional addendums for program changes throughout the year
  - ☐ Provider based goals for Adult Day Care, Behavioral Consultation, DD Waiver Nursing, and Supportive Counseling are listed under "Supports and Services" on the Supports and Services Page
  - ☐ Goals for Speech, PT, OT, Psychotherapy (optional services) are listed, if services provided by the DDA
  - ☐ Psychosocial Rehabilitation is identified on Authorization Page and Supports and Services page (\*)
  - ☐ Frequency of services and programs are consistent with the participant's needs and current situation.
  - ☐ Services and supports are consistent with past expenditures
  - ☐ Emergency Contacts listed on plan
  - ☐ Extenuating Circumstances (\*) form to justify a request for plan cost above the assigned budget
  - ☐ Health and Well-Being Checklist
  - ☐ Risk Assessment (\*)
  - ☐ Safety Plan (\*) written specific to the individual, including the average number of hours per day the individual will spend alone. Frequency of alone time listed on Supports and Services Page
  - ☐ Nursing Plan of Care (\*)
  - ☐ Implementation Plans for Residential Habilitation services
  - ☐ 6 month Status Reviews for required providers include baseline starting date for quantitative data and/or current status of participant and document the following:
    - Participant is making progress or maintaining skills or new ISP indicates adjustments
    - Services and supports correlate with current participant status
  - ☐ 6 month Plan Monitor Status Summary
    - Services requested correlate to participant's assessed needs and indicate progression or skill maintenance
  - ☐ PSR plan (\*)
  - ☐ There is no duplication of services
  - ☐ Services do not exceed 168 hours per week
  - ☐ All services are listed and costed accurately in units using the correct codes on the Authorization Page and correlate to the Supports & Services page(s)
  - ☐ DME/SME is identified on Authorization Page and Supports and Services page (\*)
  - ☐ Transportation is identified on Authorization Page and Supports and Services page (\*)- verify rate with transportation agency prior to costing
- (\*) = if applicable

## Plan Monitor Status Summary Guidelines and Instructions

The purpose of plan monitoring is to ensure you, as the advocate of the participant, and the assessors are aware of the progress, satisfaction, and barriers the participant is encountering with services in order to gain skills toward independence. The plan monitor must identify on the ISP how often the plan for the particular participant should be monitored. It must be done at least every 90 days. The Plan Monitor Status Summary identifies each of the following requirements, except the last one, as it is an immediate reporting requirement.

- Face-to-face contact with the participant to identify the current status of programs and changes the participant feels are needed.
- Contact with service providers to identify barriers to service provision.
- Discussion with the participant regarding the participant's satisfaction with the quality and quantity of services.
- Review of provider status reviews and completion of a plan monitor summary after the six month review and for annual plan development.
- An immediate report of all allegations or suspicions of mistreatment, abuse, neglect, or exploitation, as well as injuries of unknown origin to the agency administrator (the Bureau of Developmental Disabilities Services), the adult protection authority, and any other entity identified under Section 39-5303, Idaho Code, or federal law.

**Participant Name:** Type the name of the participant exactly as it appears on the Idaho Medicaid card.

**Medicaid #:** Type the first seven digits of the participant's Medicaid identification number as listed on the Idaho Medicaid card.

**Plan Monitor:** Type the plan monitor's first and last name.

**Plan Start Date:** Type the month, day, and year of the start date of the current ISP.

**Date:** Type the date the review was completed.

There are eight possible services that can be documented on this form:

- Residential Habilitation - Supported Living and Certified Family Home
- Community Supported Employment (CSE)
- Developmental Disabilities Agency (DDA) providing individual or group developmental therapy
- Supportive Counseling
- Adult Day Care
- Behavior Consultation/Crisis Management
- DD Waiver Nursing

## **Participant- Based Goals (RH-CFH, RH-SL, CSE, DDA)**

**Service Type:** Identify the general type of service being monitored - see example

For each service type include the following narrative documentation:

- **Participant Input:** Review each of the service goals with the participant and write how the participant is doing, if it is enough, too much, and what, if anything, the participant would like to do differently. Identify satisfaction with quality and quantity of services. Be concise but specific.  
**Note:** If the participant is non-verbal and chooses to have a guardian or Provider “speak” the participant’s input, you must note this here.
- **Provider Input:** Review each of the participant’s goals for each service from that provider. Summarize the provider’s input regarding progress and barriers to gaining skills. Be concise but specific.
- **Plan Monitor Input on Overall Status and Changes to Improve Progress:** Six months from the start date of the plan, review the provider status reviews and discuss any unknowns with the provider. Indicate overall progress on goals - use words such as substantial, minimal, some, etc. If no status review is received, indicate such (e.g., “Did not receive any program data from this provider”) and include a narrative on what you do know about the participant’s progress with the provider. Using all of the information gathered, identify any changes that are being made to improve progress for the participant to meet their goals from that service. Identify here if an addendum is needed and being completed to change services.

**Reminder:** If a 6-month provider status review is not received from a particular provider, the service should be removed from the plan at the point of plan submission as it will not be authorized. The service(s) may be re-added using an addendum, as needed.

## **Provider-Based Goals (Supportive Counseling, ADC, BC/CM, Nursing)**

**Service Type:** Identify the general type of service being monitored - see example

**Note:** Psychosocial rehabilitation (PSR) is not addressed on this form

For each service type, include a narrative that addresses the following questions:

- What are the services the provider is providing or training to?
- How is the participant responding to the service?
- What is the participant’s level of satisfaction with the service?
- What are the barriers to quality service provision?
- Are any changes going to be made to this service?

**Transition Progress:** For those ISPs where a transition plan is included, identify the applicable transition areas and document what phase or how much transition has taken place during the monitoring period as well as any barriers to the transition and changes that have been put in place to continue to encourage the transition to be a success. If the transition area does not apply, write N/A.

**Critical Incidents:** Include information on any critical incidents during the last reporting period. A critical incident is the process by one or more of the following is reported: abuse, exploitation, suspicious death of a participant, hospitalization, injury caused by restraints, medication error, neglect/safety issues, a participant is missing, a participant is the victim of a crime, serious injury, or violation of rights. For definitions of these areas, please contact a regional quality improvement specialist.

**Plan Monitor Signature:** The plan monitor must sign here.

## **Document Submission**

**Six month:** The six month Provider Status Reviews should be submitted to the plan monitor 15 working days from the date of the six month review in order for them to complete the six month Plan Monitor Status Summary.

**Plan Development:** The plan monitor should bring the six month Provider Status Reviews, their completed six month Plan Monitor Summary, as well as any additional information to the person-centered planning meeting to develop the annual plan. All of this information is submitted with the plan for authorization.

**Note:** A 9 month Provider Status review and Plan Monitor Status Summary do not need to be completed.

**Annual Provider Status Reviews still need to be submitted to the plan monitor, but an Annual Plan Monitor Status Summary does not need to be completed.**

## Plan Monitor Status Summary

<b>Participant Name:</b> <u>Jonathan Andrews</u>	<b>MID:</b> <u>XXXXXXX</u>	<b>Plan Monitor:</b> Susan Pike	<b>Plan Start Date:</b> <u>1-01-09</u> <b>Review Date:</b> <u>07-15-09</u>
--	-------------------------------	---------------------------------	---

### Participant Based Goals:

	<b>SERVICE TYPE: Certified Family Home</b>
<b>Participant Input</b> (Include satisfaction with quality and quantity of service)	Jonathan states that he likes to live with Deborah in her CFH. Jonathan says that he knows when to take his medications and the little blue one is for blood pressure. Jonathan says that he can take a shower every day by himself. Jonathan states that he can use his fork when he eats but he doesn't like to put his plate in the sink. Jonathan said that he likes to read the paper and find the things on sale. Jonathan states that he likes to go bowling with his friend George and wants to go to the mall to window shop.
<b>Provider Input</b> (Include barriers to service provision)	Jonathan is able to identify his blood pressure medication because the RN works with him. Jonathan has achieved stepping into the tub or shower with stand by assist. He is doing better with grabbing the towel with two hands to dry his back. Jonathan has agreed to set at the "breakfast bar" so maybe he will remember to put his plate and utensils in the sink after eating. Jonathan enjoys reading the grocery ads and picking out his favorite foods. Jonathan does need help with identifying healthy foods and not going shopping when he is hungry. Jonathan enjoys going to the mall with George and Deborah, but sometimes he has behaviors because he wants to buy everything that he sees.
<b>Plan Monitor Input</b> (On overall status and changes to improve progress)	Status report indicates that Jonathan is making substantial progress in taking medications, some progress in taking baths (but has achieved the part of stepping into the shower), and some progress in picking up after meals and using utensils, some progress in grocery shopping, some progress in participating in the community. CFH will continue to encourage Jonathan to pick healthy foods while shopping and less junk food. CFH will work with Jonathan in identifying other places than the mall to walk. Now that the weather is getting warmer CFH will talk to Jonathan about walking at the City Park.
	<b>SERVICE TYPE: Supported Living</b>
<b>Participant Input</b> (Include satisfaction with quality and quantity of service)	Jonathan reports that he can take his medications by himself using a timer and a note on his oven. He reports he does not like to get in and out of the tub by himself and is sometimes told he has to rinse better. He reports that he uses ads now for shopping and doesn't like being told he has to put stuff back. He continues to go to Cold Stone and bowling and has tried other things but doesn't like those as well. Overall he says he likes what he does and thinks he is getting more independent. He claims to always use his utensils now but not always remembering to pick up his spot after meals and reports that he doesn't think he should have to.
<b>Provider Input</b> (Include barriers to service provision)	Provider reports that they have put lots of things in place to encourage him to be independent: timer/note for meds, non-slip strips and handrails for bathtub, time set aside for looking at ads and budget, and trying to go to different places. He seems to be afraid of falling and insists upon having a hand to hold onto beyond the handrails. He also doesn't always take time to rinse his hair. He will pick up his meal spot if left until the next meal when he plans on sitting there or using the same utensils.
<b>Plan Monitor Input</b> (On overall status and changes to improve progress)	Status report indicates that Jonathan is making substantial progress in taking medications, some progress in taking baths, some progress in using utensils and picking up after meals, some progress in grocery shopping, some progress in participating in the community. Agency will institute a general shopping list to help with shopping on a budget program. Jonathan has a 'breakfast' bar area where he can eat. Jonathan wants to try eating there to see if that helps him remember to put his dishes in the sink.
	<b>SERVICE TYPE: Community Supported Employment</b>
<b>Participant Input</b> (Include satisfaction with quality and quantity of service)	Jonathan reports that he still likes his job at McDonalds and he doesn't think he needs his job coach there the whole time.
<b>Provider Input</b> (Include barriers to service provision)	Jonathan is learning the routine of cleaning the lobby. His boss has suggested adding tasks but Jonathan has refused. Jonathan hasn't been told of the possibility of more tasks being more hours and therefore more money. If he were to take on more tasks the job coach would need to be there until they became routine. If he does not take on more tasks then job coaching will be reduced to the 1 <sup>st</sup> hour of every shift. His job coach will discuss these options with him.
<b>Plan Monitor Input</b> (On overall status and changes to improve progress)	Some progress in initiating obtaining work materials. Successfully completed goal of stay on task within current work requirements. Some progress in communicating with supervisor. Some progress in seeking assistance when needed.

## PLAN MONITOR STATUS SUMMARY

	<b>SERVICE TYPE: Developmental Disabilities Agency</b>
<b>Participant Input</b> (Include satisfaction with quality and quantity of service)	Jonathan thinks he is getting more independent with the goals he is working on and mostly likes them. He would like to not have to write in the numbers on his check because that is hard. He stated that Wal-Mart does it for him so he only has to sign it. He also stated that he is getting better at talking to people but he is still uncomfortable with this. He likes practicing it with his worker in the center in private. Reports that he can now tell time.
<b>Provider Input</b> (Include barriers to service provision)	Provider reports that Jonathan will now say 'hi' to people he knows and will ask 1 to 2 word questions to his staff indicating he has a question to ask a clerk such as "how much" or "Tommy Jeans". To which the staff is helping him find a clerk and helping him ask his question. This is a major improvement. He has mastered following verbal directions in a role-play or set up scenario this is going to be moved to strictly individual community when preparing to shop for personal items. He can count change if only bills and one type of coin. Continue to work on this in center or community center using change for vending machine only. Becomes easily frustrated if staff tries to run it during purchase in community. Quickly understood date, business name and signature on check but struggles with numbers, both written and numerical. He is able to read a digital clock but not able to tell you what the time means in relation to activities. Sometimes fails to check amount written on check by clerk against total on receipt; probably will add to objectives.
<b>Plan Monitor Input</b> (On overall status and changes to improve progress)	Status review shows some progress on initiating social interactions; substantial progress in asking for assistance at stores; some progress in speaking in full sentences, substantial progress in following verbal instructions with the goal recently changed to be ran in the community while shopping for personal needs; some progress in counting change and some progress in check writing with the goal being changed to not include the legible criteria as this does not seem to be a problem at this time and confused measurability of the objective. No progress on telling time. Have provided number list 1-100 to be kept with check book to help with number writing on checks. Time is now related to his daily activities including TV shows, bowling to try to tie in the concept of what the clock says with time to do something.

### Provider Service Goals: (see page 34 for types)

#### **SERVICE TYPE: Supportive Counseling**

Jonathan states that he likes to go the "clinic" once a month to talk about how he is doing. Jonathan feels that his relationships are getting better he is getting along with his new friends. Status reviews indicate that Jonathan has made substantial progress in dealing with symptoms of anxiety and everyday situations that cause Jonathan stress. TSC will follow up with Mental Health clinic in one month to discuss the continued need for Jonathan to receive supportive counseling.

#### **SERVICE TYPE: Adult Day Care**

During his time at ADC, Jonathan has increased his social skills by playing games with others. Jonathan enjoys community outings for ice cream and going to the library. In the future, Jonathan would like to increase his exercise time and there are several other participants in the ADC group who are interested in this also. No changes at this time.

#### **SERVICE TYPE: Behavior Consultation**

Jonathan says that he likes to work with Larry (PSR) and looks forward to seeing Larry. Jonathan states that Larry is helping him learn how to calm down. Jonathan says Larry also helps him to listen to staff when shopping. Often Jonathan is able to calm down independently when somewhat excited in situations that arise in the community. Larry is able to cue Jonathan to calm down when Jonathan doesn't have the money to buy large items (airplanes and cars) and becomes overly excited. Status review states Jonathan has made substantial progress with managing anxiety while in the community, some progress with developing coping skills relating to financial stressors. Consultant will encourage Jonathan to help staff write out a budget so that he can actually see where his money is going. Jonathan's mom is his payee but since Jonathan wants to live on his own some day he will need to learn to follow a budget.

#### **SERVICE TYPE: Nursing Oversight**

Jonathan reports that he likes to have Sally the nurse come and see him because she helps him learn about his medications. Jonathan listens to Sally RN when she is educating him on when to take his medications and why he needs to take his medications. Jonathan is less resistant when a medication change is being made and understands that sometimes medications and dosages need to be changed to work more effectively. Jonathan is able to tell staff that he needs to eat before he takes his blood pressure medication. Status review states that Jonathan has made some progress on learning the purpose and frequency of his medications, some progress on understanding why at times his medications may need to be changed. Jonathan has made substantial progress in understanding how to properly take his medications. The nurse will continue to work with Jonathan on learning the purpose of medications and frequency as Jonathan benefits from repetition.

## PLAN MONITOR STATUS SUMMARY

### Transition Plan Progress (when applicable):

Transition Area	Progress Toward Steps of Transition
a. Less Restrictive Environment	Successful w/ alone time at night. Increasing to 7 hours alone at night. No changes with activities with George. George not available any more than Wednesdays. Goes to Mom's 3 Sundays a month for 4 hours. Have found affordable and trustworthy laundry and housekeeping but services have not started yet, putting money aside from job and will plan on starting at end of plan year.
b. Community Org./Activities	Has and uses bus pass with aide. Wants to get off a stop too early for all places. Does not listen for prompt.
c. Volunteer Opportunities	Cold Stone has been accepting of volunteering but only has one-hour worth of activity in the morning. If work schedule was adjusted could do 2 hours at closing. Is sweeping, mopping, taking out trash and washing front door. Needs direction to begin each activity but then does it well. Aid is there to assist at this time.
d. Independent Employment	Still struggling w/ checklist, timer and asking for feedback. Has accepted more tasks and has seen an increase in hours. CSE has not been reduced due to changes in job and learning. Has accessed the Medicaid work program and began PASS plan with IDVR.
e. Alternative Setting	N/A
f. Vocational Training	N/A

Has the participant been involved in any Critical Incidents during the last reporting period? ☐ Yes ☒ No. If yes, please provide a brief narrative including date, and the outcome of the incident.

\_\_\_\_\_  
Plan Monitor Signature/Date

## How to Initiate an Addendum

When a situation arises that requires a current service or support provider to request a modification to the existing Individual Support Plan (ISP), an ISP Supports and Services Addendum form must be submitted to the Idaho Center for Disabilities Evaluation (ICDE) for authorization. The process for initiating an ISP Supports and Services Addendum for submission to the ICDE is as follows:

- Step 1. A plan developer and/or service or support provider may initiate an addition or modification to the existing ISP.
- Step 2. The requesting provider then completes the ISP Supports and Services Addendum form according to the ISP Instruction Manual (see page 26 and 27).
- Step 3. The requesting provider reviews the completed ISP Supports and Services Addendum form with the participant or guardian (if applicable).
- Step 4. The requesting provider (if not the plan developer) forwards the ISP Supports and Services Addendum to the plan developer.

If two or more service and/or support providers submit separate ISP Supports and Services Addendums for the same participant at the same time, the plan developer can create one overall ISP Supports and Services Addendum to encompass all requests for change, if the service and support providers agree with this arrangement. The plan developer will then be responsible for obtaining all required signatures on the one overall ISP Supports and Services Addendum.

- Step 6. Once the plan developer receives an ISP Supports and Services Addendum from a service or support provider, the plan developer evaluates whether it is necessary to convene a person centered planning (PCP) meeting to discuss the proposed request and verify the participant's or guardian's (if applicable) agreement with the request as stated in the ISP Supports and Services Addendum.
- Step 7. Once it has been verified by the plan developer that the participant is in agreement with the ISP Supports and Services Addendum request, the plan developer determines the financial impact of the request relative to the participant's annual budget.

If the ISP Supports and Services Addendum request puts the plan over the participant's assigned budget, the plan developer should collaborate with the PCP team to discuss alternatives to the plan going over budget. If the PCP team determines that alternatives cannot be identified which will allow the plan to remain within the participant's budget, the plan developer, together with the PCP team, must complete an Extenuating Circumstances form.

- Step 8. The plan developer will then submit the ISP Supports and Services Addendum form along with the Extenuating Circumstances form (if applicable) to the ICDE for authorization.

## Other Information

### Durable Medical Equipment (DME)

Plan developers are responsible for helping individuals who are requesting developmental disabilities services obtain needed medical equipment and supplies and submitting Plan of Service authorization requests and addendums for costing. The following guidelines are to help the plan developer ensure that these services for the participant are authorized and captured in the Individual Support Plan (ISP) in the most expedient manner. Durable medical equipment rules are available in IDAPA rules 16.03.09.752.

It is important to remember that if the participant is enrolled with Healthy Connections, a primary care provider referral is necessary for Medicaid reimbursement of durable medical equipment and supplies (DME) or specialized medical equipment and supplies. You are responsible ensuring that this referral is obtained before requesting Medicaid reimbursement for DME or specialized medical equipment.

#### State Plan DME

- When you determine a participant needs any medical equipment or supplies during the person centered planning meeting or at any other time, the plan developer will consult with the medical equipment vendor to determine whether the requested equipment or supplies are covered under Medicaid's DME and require prior authorization.
- Refer to the DME provider handbook for the prices and what items need to be prior authorized by the DME specialist in the department. Refer to the Medicaid Fee Schedule pricing guide on the internet at [www.dme.idaho.gov](http://www.dme.idaho.gov).
- If the equipment or supplies are not covered under the State Plan and the individual is either receiving or applying for waiver services, you should follow the procedure for specialized medical equipment and supplies.
- Once you determine that the equipment or supplies are covered under Medicaid, please use the following protocol for submitting the plan of service that includes DME:
  - If no prior authorization is required, you can select a Medicaid vendor through the person centered planning team process and consult with that vendor for the price and appropriate code. Use the vendor "quote" for the cost of the DME supply or equipment on the ISP and submit the plan to the assessor.
  - If prior authorization is required, the request including the procedure codes and prices is submitted by the medical equipment vendor to the DME unit. To ensure the authorization is completed by the DME unit, the plan developer must get a valid price from the vendor and obtain a copy of the AIM prior authorization notice before putting the supply or equipment on the ISP. The authorization must be completed by the DME unit before the ISP is submitted. The plan developer must submit a copy of the prior authorization notice along with the ISP to the assessor.

#### Specialized Medical Equipment and Supplies - DD and ISSH Waivers Only

- Before requesting specialized medical equipment or supplies, the plan developer or TSC must first attempt to access these services through all other resources. The plan developer or TSC must provide documentation from a professional validating the need for the requested equipment specific to the participant. Specialized medical equipment doesn't include convenience items or devices. The procedure code for specialized medical equipment is E1399-U8.
- Requests for specialized medical equipment will come to the assessor for review on the ISP.

- If technical assistance is needed to determine the type of information needed to justify the need for DME, contact the DME specialist in the Medical Care Unit at:

Phone: (208) 364-1830  
(208) 364-1954  
(866) 205-7403  
Address: PO Box 83720  
Boise, Idaho 83720-0036

To find complete guidelines regarding DME and specialized medical equipment, please refer to your Provider Handbook.

## **Guidelines for Developing Person Centered Plans that Encourage Independence**

Every effort must be made to develop services and supports that meet the participant's identified needs in the most independent manner. Participants should be encouraged and helped to find activities and develop relationships in their community. In considering the questions below, you succeed in helping the participant realize independence, identify natural supports, and reduce dependence on services. This in turn helps provide the paid services they need within their approved budget.

Here are some questions you can ask:

- Are the activities on the plan based on the participant's choice?
  - Do they support their life goals or slow them down?
- Do they need to learn skills to succeed in the activities, or do they just need assistance to access the activity?
  - Do they need training or just assistance in finding/accessing transportation?
  - Are the goals achievable?
- How much time are they able to focus on what is being taught?
- How often do they need to practice the skill in order to learn the skill?
- Is the skill being taught in the setting where they need to use it to be successful independently?
  - Should it be taught in a community activity of interest?
  - Should it be taught with a group of individuals instead of individually?
- Are there duplicative services? If so, eliminate all duplications.
- How much supervision is required for the participant to be safe and effective?
  - Do they need a job coach through their entire working shift?
  - Do they need night supervision?
  - Do they need to be up and awake?
  - Do they need supervision during all waking hours or could they be left alone for periods of the day?
  - Could they share a staff that could supervise both of them at the same time?
- Would services such as personal emergency response systems and home delivered meals make them more independent yet still provide for their safety and needs?
- What natural (unpaid) supports can take the place of paid supports?

## **Adding Waiver Services When There is an Existing ISP**

If a participant is on a state plan ISP and wants to access DD waiver services before the next annual ISP, they must submit a waiver application to the assessor at ICDE. If the participant has been seen within 120 days, the assessor does not need to see them. If it is over 120 days, they will need to be seen and the SIB-R re-administered if it falls within the guidelines requiring a more current SIB-R. Following the determination for waiver, the assessor will send out a waiver eligibility letter with a new calculated budget. The plan developer must then convene a person-centered planning (PCP) team meeting to initiate a new initial waiver ISP. An addendum cannot be used to add initial waiver services. The date of the new waiver ISP becomes the new annual re-determination date.

Each of the following forms must be submitted to the Idaho Center for Disabilities Evaluation (ICDE) before a new annual waiver ISP can be processed for authorization:

- Supports and Services Authorization form
- Signature Page form
- Personal Summary form (includes Assessed Needs and Transition Plan - if applicable)
- Supports and Services form(s)
- Health and Well-Being Checklist
- Extenuating Circumstances form (if requested services put the participant over their authorized budget amount)
- Safety Plan (if applicable)

## Change in Plan Developer Within the Plan Year

If a participant chooses to change their plan developer within the current plan year and the new plan developer is employed by a different service coordination agency, the request for the change in plan developer and plan development hours (if there are any within the 12 hours left) must be submitted on an Individual Support Plan (ISP) Supports and Services Addendum form to the Idaho Center for Disabilities Evaluation (ICDE) by the new plan developer.

The following questions should be taken into consideration by the new plan developer when generating the addendum:

- Does the new plan developer need to request hours for plan development for the rest of the plan year?
- Does the new plan developer need to develop an ISP Supports and Services Addendum to change participant goal(s)?
- Does the new plan developer need to develop an ISP Supports and Services Addendum to add or delete services?

## Statewide Bureau of Developmental Disabilities Phone List

<b>Regional Medicaid Services</b>	
For assistance not found in this manual, review of crisis requests, application for services	
Region 1	(208) 769-1567 Select Regional Medicaid
Region 2	(208) 799-4430 or (877) 799-4430 Select Adult Developmental Disabilities Program
Region 3	(208) 455-7150
Region 4	(208) 334-0940
Region 5	(208) 736-3024 or (800) 826-1206
Region 6	(208) 239-6260
Region 7	(208) 528-5750

<b>Independent Assessment Providers</b>	
For eligibility and plan submission process	
Region 1	(208) 772-8502
Region 2	(208) 799-5044
Region 3	(208) 467-4849
Region 4	(208) 373-1730
Region 5	(208) 736-5711
Region 6	(208) 282-5465 or (800) 999-4781
Region 7	(208) 525-7050

<b>Adult Protection Services</b>	
For reporting of suspected abuse, neglect or exploitation	
Region 1	(208) 667-3179
Region 2	(208) 743-5580 or (800) 877-3206
Region 3	(208) 322-7033
Region 4	(208) 322-7033
Region 5	(208) 736-2122
Region 6	(208) 233-4032 or (800) 526-8129
Region 7	(208) 522-5391

## Web Site Links

### **General Health and Welfare information:**

<http://www.healthandwelfare.idaho.gov/site/3465/default.aspx>

### **Adult DD Care Management: Forms, Partnership Meeting Minutes, DD Application information, Transportation information, etc:**

<http://www.healthandwelfare.idaho.gov/site/3597/default.aspx>

### **Self-Direction information:**

[www.selfdirection.idaho.gov](http://www.selfdirection.idaho.gov)

### **Idaho Health:**

<http://www.idahohealth.org/>

### **Rules:**

<http://adm.idaho.gov/adminrules/rules/idapa16/16index.htm>

### **Idaho Statute:**

<http://www3.state.id.us/idstat/TOC/idstTOC.html>

### **Federal Regulations:**

<http://www.gpoaccess.gov/cfr/index.html>

### **Medicaid Provider Handbook**

<http://www.healthandwelfare.idaho.gov/site/3438/default.aspx>

### **DME Information**

[www.dme.idaho.gov](http://www.dme.idaho.gov)

### **Medicaid Fee Schedule:**

<http://www.healthandwelfare.idaho.gov/site/3502/default.aspx>